Fletcher Allen HEALTH CARE
In alliance with The University of Vermont

MEMORANDUM

Executive Office

To: Anya Rader Wallack
Chair, Green Mountain Care Board
From: Roger Deshaies
Chief Financial Officer
Date: July 2, 2012
Subject: Fiscal Year 2013 Operating and Capital Budgets

Executive Summary

Vermont has set out an ambitious agenda to ensure that all of us who pay for health care – businesses, families, government – are paying for a system that delivers high-quality, safe, affordable care. Getting overall health care costs under control is an important first step. Two key building blocks will serve as the foundation for that work: payment reform and delivery system reform. Under the leadership of our new President and Chief Executive Officer, Dr. John Brumsted, Fletcher Allen is committed to both facets of reform, and we are actively working with the State to create a comprehensive outcomes-based delivery and payment system – not simply to bend the cost curve, but also to achieve a higher-quality, more effective and affordable care system with improved access for all Vermonters. Our FY 2013 budget was crafted by staff and management to advance that goal while staying within the 3.75% net revenue increase target established by the Green Mountain Care Board.

Fletcher Allen is taking two approaches to payment and delivery system reform: developing an integrated delivery system that will support improved clinical care delivery while enhancing our academic mission, and examining new ways to collaborate with Vermont providers within a new, more tightly-integrated network to deliver coordinated, personalized care to the patients we serve in the right time and right place.

The first of these strategies is happening under the aegis of Fletcher Allen Partners, created last October with the affiliation of Central Vermont Medical Center and Fletcher Allen Health Care. That integrated delivery system is set to expand later this year with the addition of Champlain Valley Physicians Hospital and Elizabethtown Community Hospital, both located in New York. Working within Fletcher Allen Partners, our integrated delivery system is already yielding clinical benefits, like the establishment of a telemedicine link between the intensive care unit at CVMC and intensive care specialists at Fletcher Allen that allows more critically-ill patients in Central Vermont to remain near their homes, yet benefit from highly specialized intensive care expertise. To date this fiscal year, for example, seven ICU consultations were completed, with only two of

the patients being transferred to Fletcher Allen; the remaining five were able to stay at CVMC. Our partnership is yielding operational benefits as well: because of our economies of scale, we have already seen substantial savings in purchases of equipment, supplies and pharmaceuticals, and are on track to save approximately $1 million in expenses this year alone.

The second strategy – creating a more tightly-integrated provider network able to accept financial risk for patient populations – is at the heart of our payment reform model, and is leveraging our fifteen years of experience with Fletcher Allen's Jeffords Institute for Quality and Operational Effectiveness, which has a long history of supporting standardization and reductions in clinical practice variations, as well as Vermont Managed Care, our wholly-owned physician-hospital organization (PHO) subsidiary that currently administers population-based accountable health care plans for MVP Healthcare and TVHP. The overarching goal of this physician-led, patient-centered integrated care model is to develop the infrastructure to support additional provider networks in delivering coordinated, personalized care, focused on the patient and aligned with all best practices.

This clinical delivery system redesign will include physician champions leading change in key clinical areas and at VMC to support:

- Developing a population-level quality/value report card that will have financial impact in the payment reform model for the network;
- Demonstrating centralized data and analysis capability to support evidence-based, coordinated patient care;
- Developing an annual plan for expected clinical improvements in wellness, chronic disease management, the delivery of procedure-based care, and other focus areas expected to decrease costs and improve patient outcomes, quality of care and satisfaction; and
- Strengthening a physician alignment plan that minimizes or eliminates mixed incentives for individual physician behavior.

These initiatives do not come without costs, however. Robert Murray, one of the GMC Board's payment reform consultants, recently outlined several basic principles that formed the foundation for successful payment reform in Maryland, including the need for hospitals to assume financial risk – something that Fletcher Allen already does through its subsidiary, Vermont Managed Care, and which we plan on expanding. He also noted, however, that regulators need to "jumpstart and facilitate payment reform by providing upfront targeted "seed funding" to help hospitals invest in [those] needed delivery system changes."[1]

Fletcher Allen is committing real resources – $20.8 million in FY 2013 – to the payment reform initiatives we are embarking upon (*see* Attachment A). These include continued investments in the patient-centered medical home model of primary care, new expenses

[1] *See* "Transitioning to New Payment Models: Experience from Maryland," presentation to the GMC Board, May 29, 2012 (http://gmcboard.vermont.gov/sites/gmcboard/files/VAHHS_052912.pdf), slide 4.

associated with our electronic medical record and information technology capabilities needed to support population-based care management, as well as the expenses associated with the time being committed to these efforts by our human resources (including medical directors, the staff of the Jeffords Institute for Quality and Operational Effectiveness, members of our Planning & Network Development Department, and members of our leadership). With those resources, among others, Fletcher Allen is developing the infrastructure (including information technology and data management capabilities) necessary to move more Vermonters into certified medical homes, migrating new populations into new payment models, developing methodologies to meet outcomes-based metric targets, and using our expertise as an academic medical center to perform research and analysis as to the effectiveness of the model.

Our goal is to build on existing populations managed through VMC (about 45,000 Vermonters) with additional population-based, non-fee-for-service models over the next two to three years. We estimate that these population-based payment models could cover as many as 200,000 covered lives in that time period. Populations being considered include Medicare beneficiaries under a shared-savings accountable care organization (ACO) model; commercial populations under accountable care contracts (akin to what has happened in Massachusetts in the past several years); and Medicaid beneficiaries in the network's service area. In fact, together with Central Vermont Medical Center, we have just entered into a shared-savings "collaborative accountable care" contract with Cigna, which will apply to approximately 10,500 Cigna members served by Fletcher Allen Partners providers.

In order for us to advance our payment and delivery system reform initiatives, Fletcher Allen must be financially strong and financially sustainable – another reform principle outlined by the Board's consultant. To that end, our FY 2013 includes an operating margin that we have been targeting for a number of years: 4%. That margin is key to our ability to help lead health care reform in Vermont, as outlined above; it is also the foundation for our ability to continue meeting our mission while we transition into the transformed system. It will allow us to move towards our long-stated goal of achieving an A-level bond rating, which will in turn support not only our routine capital needs over the next few years, but also much-overdue investments in our inpatient physical infrastructure.

We note that achieving our financial goals in FY 2013 is especially challenging in light of the continued underpayments from public programs, particularly Vermont's Medicaid program. Despite the commitment in Act 48 to financing that is "sufficient, fair, predictable, transparent, sustainable and shared equitably,"[2] this year's state budget did nothing to address the cost-shift. That means that rate increases related to our FY 2013 budget are, once again, disproportionately borne by the 40% of our payers that are "rate sensitive" – meaning the commercial plans we contract with. Since neither Medicare nor Medicaid will pay us any differently regardless of what rate increase we are authorized to get, our budget is predicated on a 9.4% rate increase to those commercial plans. That rate is necessary even with our budget assumption that Fletcher Allen will actually receive

[2] Act 48 (2011 Sess.), Section 1a(11).

additional funds from Medicaid to support our academic mission, including graduate medical education and the unique services we provide, in FY 2013; those payments have been under discussion with the Department of Vermont Health Access (DVHA) since last year. Should those funds not materialize, we will need to come back for a budget adjustment to fill that gap.

In addition, the loss of the Medicare Boston wage index created a $15 million hole in our revenues when compared with our FY 2012 budget.

In summary, Fletcher Allen's FY 2013 budget is a tight, disciplined budget that:

- Stays well within the inflation factor assumed by the Board for the fiscal year;
- Is within the Board's 3.75% cap on growth in net patient revenue; and
- Supports the 4% margin that Fletcher Allen needs to continue to meet our mission while advancing the state's twin goals of payment and delivery system reform.

We believe that our ability to engage in those reforms at the level we are committed to would be put at risk by a budget with any material changes from what we have proposed.

In addition to the risk presented should we not receive the anticipated enhanced Medicaid payments, there are other risks in our budget as presented:

- There is no assurance that we will be able to obtain from our commercial payers through contract negotiations the rate increases required by our budget.
- Approximately $13 million in revenues are attributed to two payment arrangements that are or may be time-limited. These include "meaningful use" payments of $6 million and revenues associated with the expansion of our 340B drug program.

Should any of these assumptions prove incorrect, it will have a material impact on our proposed operating margin.

In the following pages, the FY 2013 budget is presented in the format prescribed in the *Uniform Reporting Manual Supplement.*

1) Budget-to-Budget Expense Increases (RECON Schedule)

The RECON schedule for FY 2013 (Attachment B) shows an overall expense increase of 7.7%, which includes an increase of 0.4% relating to utilization, operational increases of 2.4%, capital reduction of -0.3%, inflation increases of 2.4%, and an increase of 3.0% relating to extraordinary expense changes as compared to FY 2012.

Major changes in spending as identified in the crosswalk include:

- **Utilization:**
  - Expenses as identified by the VOLCOST table, which account for 0.4% of the total variance.

- **Operations:**
  - New 340b retail pharmacy program (revenues generated from the program are expected to exceed this projected expense).
  - Expansion of our Patient-Centered Medical Home model of primary care (fully-funded through Blueprint for Health revenue).
  - Investments in additional personnel to address performance and capacity needs relating to the continued development of our integrated health system and our health care reform efforts.
  - ICD-10 implementation costs**.**
  - Physician salary expense increase relating to their compensation plan**.**

- **Capital Expenses:**
  - Decrease in interest expense relating to a debt refinancing opportunity that we identified and took advantage of this year.

- **Inflation:** The Fletcher Allen budget includes approximately $22.9 million of directly-calculated price inflation, an inflation rate of 2.4%, well under the Board's inflation rate of 2.9%.

- **Extraordinary Expenses:** All of these expenses are described in detail in Section 7(a), below, in our request that they be exempted from our revenues and expenses as allowed under Act 128 and Act 48.
  - Provider tax increase of $5.1 million.
  - $7.0 million increase in direct new costs related to payment and delivery system reforms (part of the $20.8 million in overall costs associated with these efforts discussed in more detail in the Executive Summary, above).
  - Additional expenses of $1.9 million associated with the closing of the Vermont State Hospital (VSH) and our accepting Level 1 psychiatric patients (primarily nurse staffing increases).
  - Increased academic support payments to the University of Vermont of $14.3 million.

2) CON-Related Capital and Operating Expenses (FY 2012 projected)

Fletcher Allen was granted a Certificate of Need (CON) in April for the development of a hybrid operating room (OR), and associated renovations to other ORs, on our Medical Center Campus, with an approved capital cost of $5.2 million. At this time, we do not anticipate there to be any material changes to the project as approved.

3) Price Changes

Fletcher Allen's FY 2013 budget includes a 9.4% overall rate increase. This increase will yield increased revenues of $36.5 million.

The overall rate increase represents a 16% increase in inpatient prices (allowing us to rebalance our inpatient prices to existing market rates), an 8.6% increase in outpatient prices, and a 4.9% increase in professional fees. We will make final determinations as to allocation of price increases after the budget receives final approval.

4) Asset Transfers

The FY 2013 operating budget assumes no asset transfers to or from restricted funds, hospital subsidiaries, parent organizations or other organizations.

Although Fletcher Allen has several subsidiaries, material transactions between Fletcher Allen and its subsidiaries are budgeted as with any other third-party vendor:

- Funding for self-insured professional liability through VMCIC is budgeted as insurance premium expense.
- Payment received for services to patients insured through Vermont Managed Care is budgeted as patient service revenue.

5) Budget-to-Budget Revenue Changes

a) Medicare reimbursement assumptions

We have budgeted an increase in Medicare payments for inpatient services of 0.7%, an increase of 1.2% for outpatient services, and no change for professional services. Those assumptions differ from what the budget instructions requested, but we believe they are appropriate since they are based on the proposed rules issued by the Centers for Medicare and Medicaid Services (CMS). Those rules will not be finalized for several months (August for inpatient rates, and November for outpatient and professional rates).

The major change in our Medicare assumptions is the loss of our Boston Area Wage Index classification, which will reduce our reimbursement by approximately $15

million. We have made no change in assumptions about the proportion of Medicare cases to our overall number of discharges.

b) Medicaid reimbursement assumptions

We assumed no changes in either out-of-state or Vermont Medicaid payment rates. As we have noted in previous years' budget submissions (as well as many other forums), Medicaid payments continue to deteriorate, to the point where net payments in FY 2012 are significantly lower than in any of the four previous state fiscal years, despite the fact that our Medicaid volumes continue to increase:

(in millions)	SFY08	SFY09	SFY10	SFY11	SFY12
Medicaid receipts	$ 51.3	$ 63.1	$ 68.5	$ 79.0	$ 80.4
Plus DSH receipts	$ 23.3	$ 16.7	$ 17.3	$ 16.7	$ 18.7
Total receipts	$ 74.6	$ 79.8	$ 85.8	$ 95.7	$ 99.1
Less provider tax paid	$ 30.8	$ 33.7	$ 36.5	$ 45.9	$ 52.8
Net revenue To Fletcher Allen	$ 43.8	$ 46.1	$ 49.3	$ 49.8	$ 46.3
Less FA's Medicaid program costs	$ 91.6	$ 105.5	$ 112.4	$ 119.5	$ 123.1
FA's unreimbursed Medicaid costs	**$ (47.8)**	**$ (59.4)**	**$ (63.1)**	**$ (69.7)**	**$ (76.8)**
Cost coverage ratio	**48%**	**44%**	**44%**	**42%**	**38%**

As mentioned in the Executive Summary, we have been working for the past year with DVHA to enhance Medicaid payments to Fletcher Allen based on our academic mission. Should those payments materialize during this fiscal year – which we have assumed in this budget – those revenues would improve, but not resolve, the problem of Medicaid underpayments to Fletcher Allen.

c) Commercial payer reimbursement

Our budget assumes a net revenue increase from the commercial payers equal to the overall fee increase of 9.4%. This is necessary in order to meet our stated financial objective of obtaining a 4% operating margin.

d) DSH receipt assumptions

DVHA has estimated Fletcher Allen's DSH receipts for FY 2013 to be $18,115,526. That figure has been incorporated into our budget.

e) Expenses (major changes not related to inflation)

Major changes in our budget are discussed in Section 1, above.

6) Capital Budget

Fletcher Allen's capital budget for FY 2013 is $51.0 million, which represents 103.5% of our FY 2013 depreciation budget. Approximately $7.9 million of this amount is set aside for several projects that we anticipate will require CON review, including a Cath Lab

replacement and facilities upgrades relating to our Master Facilities Plan. The remaining $43.1 million of planned capital expenditures is for routine equipment replacement, routine facilities work, information systems infrastructure, and strategic and emergent needs.

7) Other Key Budget Elements and Assumptions

a) Exempted costs. In addition to the increase in provider taxes of $5.1 million, Fletcher Allen is requesting the exemption of $39 million of total operating revenue from the Board's revenue target, as follows. (*See* Attachment C for a detailed table of requested exemptions.)

- **Enhanced Medicaid payments in support of our academic mission.** We are requesting exemption of $30 million in net revenue relating to the enhanced funds we anticipate receiving from DVHA in this fiscal year. These funds are meant to support academic missions identified by the University of Vermont, the UVM Medical Group, and Fletcher Allen.

- **Payment and delivery system reform initiatives.** Our budget includes $7 million in new expenses relating to payment and delivery system reform activities described in the Executive Summary: $3.8 million of this is associated with information technology and electronic health record expenses, and $3.2 million relates to expenses associated with the continued development of Fletcher Allen Partners, our integrated delivery system. This work requires considerable resources in the form of both staff time and enhanced data management and analysis. These are necessary expenses that are completely aligned with Vermont's ongoing reform efforts, and are in addition to other expenses we are currently incurring in support of our reform initiatives (discussed in the Executive Summary, above).

- **VSH.** Included in this budget submission are additional costs and revenue associated with the tentative agreement between VSH and Fletcher Allen to provide acute inpatient beds on an interim basis. The expenses are associated primarily with the hiring of new staff needed for the Level 1 patients we are caring for. We are requesting that $2 million in additional revenue be included in our list of exemptions.

b) Utilization assumptions. Overall, FY 2013 volumes are expected to remain mostly flat when compared to the FY 2012 budget, with individual areas showing both increases and decreases.

Key inpatient drivers such as admissions and patient days are expected to see a decrease of -1.2% and -0.9% respectively. Areas also expected to see decreases include the operating rooms (-2.3%), cath lab/EP procedures (-4.4%), and Radiation Oncology (-4.3%). These are partially offset by increases in lab services (5.7%), emergency department visits (2.6%), and radiation procedures (2.2%).

	FY 2011 Actual	FY 2012 Budget	FY 2012 Projected	FY 2013 Budget
Inpatient				
Admissions	21,975	22,485	22,371	22,213
Patient Days	116,471	118,262	119,278	117,241
Average Length of Stay (discharge days/discharges)	5.36	5.26	5.38	5.28
Inpatient & Outpatient				
OR Cases	18,428	18,588	18,528	18,153
Cath Labs & EP Procedures	5,224	5,625	5,222	5,377
ED Visits	60,484	59,954	59,467	61,495
Radiology Procedures	248,629	248,524	253,822	253,880
Radiation Oncology	37,344	38,337	37,202	36,705
Labs	2,742,351	2,749,677	2,926,709	2,907,097

Note: *Projected FY12 is based on FY12 YTD April Annualized*

The professional work Relative Value Unit (RVU) budget for the UVM Medical Group in FY 2013 is flat compared to what was budgeted in FY 2012, while physician FTEs are decreasing by 6, or 1.21%.

c) Provider tax assumptions. For purposes of this budget, we have also assumed that no provider tax would be assessed on the $30 million in enhanced Medicaid payments that we anticipate receiving in this fiscal year (discussed in more detail above). Should that assumption be incorrect, it would increase our expenses by $1.8 million.

	Current Expense Allocated / Re-deployed	New 2013 Budget	Total
Grand Total	**$ 13.8**	**$ 7.0**	**$ 20.8**
I.T./PRISM		3.8	3.8
Additional FAP Expense		3.2	3.2
Transformation of Primary Care (UVM Medical Group)	1.4		1.4
Medical Directorships (10%)	0.3		0.3
Institute of Quality & Operational Effectiveness (25%)	1.1		1.1
Planning & Network Development (50%)	0.6		0.6
FACT	0.5		0.5
Leadership Administrative Effort	1.0		1.0
Community Health Team	2.8		2.8
Medical Home (UVM Medical Group)	0.9		0.9
VMC			
Population Medical/Case Management	2.2		2.2
Managed Care Financial Management and Analysis	1.5		1.5
Network Development, Relations, and Contracting	1.5		1.5

FLETCHER ALLEN HEALTH CARE
TOTAL OPERATING EXPENSE CROSSWALK
FISCAL YEARS 2012 - 2013
(In $000's)

FY 2012 Operating Expense Budget					956,852
Utilization					
	VOLCOST Variable Expense Calculation	3,355			
			3,355	0.4%	
Operations					
	340B Retail Pharmacy	10,314			
	Physician Funding Plan	3,261			
	Benefits Increase (Anty, FICA, Hlth, Dental)	3,061			
	PCMH Expansion	2,427			
	Investment in addn'l personel to address perf and capacity needs	2,095			
	ICD10 Implementation	1,044			
	Miscellaneous Expenses	291			
			22,494	2.4%	
Capital Expenses					
	Interest	(2,664)			
	Depreciation	(603)			
			(3,266)	-0.3%	
Inflation					
	Physician and Residents salaries	332			
	Staff salaries	12,828			
	Payroll Tax and Benefits	5,820			
	Supplies (Med/Surg, Pharm, Nutrition, etc)	3,305			
	Utilities	409			
	Insurance	212			
			22,907	2.4%	
Extraordinary					
	Provider Tax	5,078			
	Payment and Delivery Reform - I.T. / PRISM	3,768			
	Payment and Delivery Reform - FAP	3,200			
	Increased academic support payments	14,324			
	VSH additional expenses	1,900			
			28,270	3.0%	
Total Increase in Operating Expense					73,759 7.7%
FY 2013 Operating Expense Budget					$1,030,611

Reconciliation to State's 3.75% Revenue Cap

Revenue	FY 2012 Budget	FY 2013 Budget	Change from '12-'13 Budget		Requested Exemptions	Remaining Change After Exemptions	
			Amount	%		Amount	%
Inpatient Revenue	580,161,306	664,255,888					
Outpatient Revenue	864,816,612	967,566,019					
Professional Revenue	670,696,137	697,793,418					
Total Patient Revenue	2,115,674,055	2,329,615,324					
Deductions*	1,174,827,706	1,314,768,812					
Net Revenue Prior to Tax	940,846,349	1,014,846,513	74,000,163	7.87%			
Less Provider Tax	53,573,255	58,651,329	5,078,074	9.48%			
Net Patient Revenue	887,273,094	956,195,184	68,922,089	7.77%	(38,967,694)	29,954,395	3.38%

Additional Requested Exemptions to State's 3.75 Net Revenue Cap

Enhanced Medicaid Payments	(30,000,000)
VSH Additional Reimbursements (net revenue)	(2,000,000)
Payment and Delivery reform - I.T. / PRISM	(3,767,694)
Payment and Delivery reform - FAP	(3,200,000)
Total Requested Exemptions	**(38,967,694)**

* Deductions do not include the cost of the provider tax.